



The Center for Child Development  
Neuropsychological & Therapeutic Services

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information, which may identify you and relates to your past, present or future physical or mental health or condition and related health care services, is referred to as Protected Health Information (“PHI”). This Notice of Privacy Practices describes how I may use and disclose your PHI in accordance with applicable law. It also describes your rights regarding how you may gain access to and control your PHI.

I am required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. I am required to abide by the terms of this Notice of Privacy Practices. I reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that I maintain at that time. I will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:**

**For Treatment.** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. I may disclose PHI to any other consultant only with your authorization.

I may leave a message for you regarding an appointment. If you want to call you only at work or at home, I can usually arrange that. I often leave messages on home answering machines; if this creates a problem, please let me know. I also use cell and cordless phones and privacy cannot be guaranteed with these devices.

**For Payment.** I may use or disclose PHI so that I can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, I will only disclose the minimum amount of PHI necessary for purposes of collection.

**For Health Care Operations.** I may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, reminding you of appointments, to provide information about treatment alternatives or other health related benefits and services, licensing, and conducting or arranging for other business activities. For example, I may share your PHI with third parties that perform various business

activities (e.g., billing or typing services) provided I have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

**Required by Law.** Under the law, I must make disclosures of your PHI to you upon your request. In addition, I must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization.**

**Abuse and Neglect  
Emergencies  
National Security**

**Judicial and Administrative Proceedings  
Law Enforcement  
Public Safety (Duty to Warn)**

**Without Authorization.** Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat, it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

**Verbal Permission.** I may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization.** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

## **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding your personal PHI maintained by our office. To exercise any of these rights, please submit your request in writing to Philip Dunbar-Mayer, Psy.D., at 2310 130<sup>th</sup> Ave NE, Suite B-101, Bellevue, WA 98005:

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. I may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI I have about you is incorrect or incomplete, you may ask us to amend the information, although I am not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that I make of your PHI. I may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. I am not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this Notice.
- **Electronic Transactions Standards.**

## **COMPLAINTS**

If you believe that I have violated your privacy rights or you disagree with a decision that I make regarding access to your PHI or Progress Notes, you may contact the Examining Board of Psychology at 360-236-4910 or by writing them at P.O. Box 47869, Olympia, WA 98504-7869. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201, or by calling (202) 619-0257. **I will not in any way limit your care or take any actions against you if you file a complaint.**

**The effective date of this Notice is 10.24.2014**

**Philip Dunbar-Mayer, Psy.D.**  
**Licensed Psychologist #PY00003829**  
Phone: (425) 877-3484      Fax: (425) 702-0600  
**Notice of Privacy Practices**

**Receipt and Acknowledgment of Notice**

Client Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Philip Dunbar-Mayer's Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Philip Dunbar-Mayer at 2310 130<sup>th</sup> Ave NE, Suite B-101 in Bellevue, WA 98005.

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Signature or Parent, Guardian or Personal Representative \*

\_\_\_\_\_  
Date

\* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

\_\_\_\_\_  
Signature of Staff Member

\_\_\_\_\_  
Date